2720 N Harbor Blvd, Ste 210 Fullerton, CA 92835
Phone: 714-446-5192
Fax: 714-515-8360
www.align-spine.com

Name: _____

E-mail: _____

D.O.B. _____ **Age:** _____

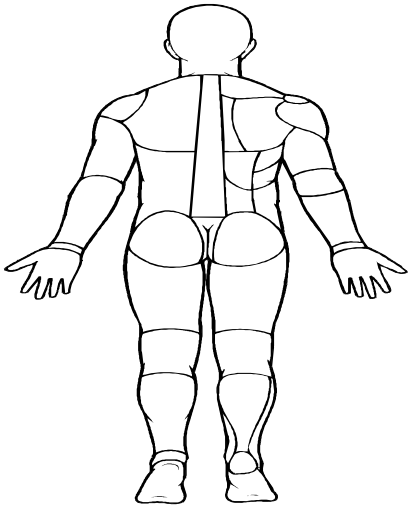
Who is your primary care physician & referring doctor?

_____

What is the major reason you are coming to see the doctor?

_____

Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.



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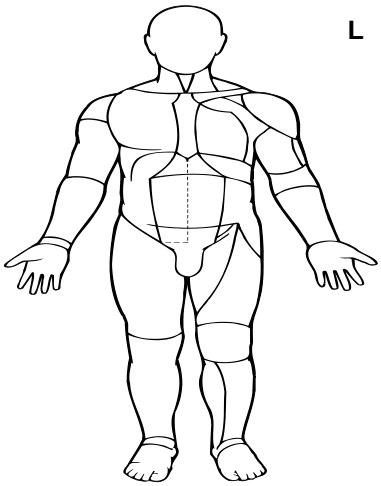

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When did the pain start? _____

What were you doing when the pain first started? _____

How long does the pain last? ☐ Constant ☐ Intermittent

QUALITY OF YOUR PAIN: (Please mark all that apply):

( ) Throbbing ( ) Cramping ( ) Pins and needles ( ) Aching ( ) Shooting
( ) Stabbing ( ) Sharp ( ) Hot-burning ( ) Other_____

Intensity of Pain

On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

align SPINE CENTER
Making A Difference One Level At A Time

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Have you experienced any numbness, tingling or weakness? If Yes, which one and where?

_____

What makes your pain worse? Mark all that apply.
( ) Bending ( ) Lifting ( ) Sneezing/Coughing ( ) Walking ( ) Standing ( ) Sitting
( ) Other, please explain _____

What makes your pain better? Mark all that apply.
( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat
( ) Cold ( ) Lying in a fetal position ( ) Lying on your back
( ) Lying on back with pillows under your legs
( ) Medication(s), please list _____
( ) Other, please explain _____

Have you experienced any weight loss, fever or chills? If Yes, which one(s)?

_____

How many blocks can you walk before needing to stop due to these symptoms?
____blocks ( )unlimited

Are these symptoms significantly affecting your quality of life and ability to perform activities of daily living?
( )Y ( )N

Do the symptoms wake you up at night? ( )Y ( )N

Have you noticed: ( )Change in handwriting ( ) Dropping of objects ( )Walking Imbalance

Do you have full control of your bowel and bladder? ( ) Yes ( ) No
If no, explain_____
Have you had surgery for this problem? ( )Yes ( )No
If yes, enter date(s),surgeon(s), and procedure(s):
_____
Did the surgery help?( )Yes ( ) No

TREATMENT HISTORY
Which of the following types of caregivers have you visited prior to your arrival here?
( ) Family Physician/Internist ( ) Spine Surgeon ( ) Orthopedic Surgeon ( ) Neurologist
( ) Rheumatologist ( ) Pain Management ( ) Chiropractor ( ) Acupuncturist ( ) Physical Therapist
( ) Other, please list_____

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Please check the medications that you have tried for your pain in the past and their effectiveness.

(0=no help, 10=very helpful)	**Tried Medication**		
Name of medication	Yes	No	**Effectiveness (0-10)**
Tylenol/acetaminophen			
NSAID's: Motrin/Advil/Ibuprofen, etc			
Opioids: Vicodin/Norco/Oxycodone, etc			
Oral Steroids/Medrol dose pack			
Amitriptyline(Elavil), Nortriptyline(Pamelor), etc			
Muscle relaxants/Flexeril			
Neurontin/Topamax/Tegretol, etc			
Marijuana/Cocaine/Heroine/Other illicit drugs			
Xanax/Ativan/Valium,etc			